**Strong Connections, Stronger Families**

Heather Fitzpatrick: Hello and welcome. Thank you for joining us today for Strong Connections for Strong Kids, a webinar on models of collaboration for medical home and Head Start and Early Head Start programs. This webinar is the first in a series of three we'll be presenting as part of the Head Start National Center on Health efforts to support increased collaboration between Head Start and Early Head Start programs and the health care community. My name is Heather Fitzpatrick, and I am on staff at the American Academy of Pediatrics which functions as the administrative lead for the Cooperative Agreement for the National Center on Health.

Before we begin today's webinar, I would just like to cover a few housekeeping items. First, regarding the presentations, if you are using Wi-Fi and are not hard-wired, you may experience a greater lag time during the presentation. The slides will advance automatically throughout the presentation. Attendees will not have control over the slides. All attendee lines are muted, but if you have a question, we encourage you to type your question in the "ask a question" box on your screen.

There will be a short Q&A session, question and answer session at the end of the webinar. If we do not have time to address your question during the webinar, we will provide a direct response within a couple of weeks. In addition, we will post responses to all questions with the materials on the ECLKC. If you are listening to the webinar by phone, please click on the "listen by phone" button that is just above the "ask a question" box.

To view the presentation in full screen, please click on the black button at the upper right-hand corner of the presentation slides. After the webinar, you will be redirected to an online evaluation. Please take a few moments to share your feedback on today's events. We really appreciate that. Only participants who complete the evaluation will receive a certificate of participation. If you are watching as a group, the person who logged in for the webinar will also receive an email with a link to the survey. We ask that you share this link with the rest of your group so that they can complete the evaluation and receive a certificate, as well. If you need technical assistance during the webinar, please just enter a question in the question box and we'll do our best to help you. During today's webinar, our speakers will be sharing various models on strengthening collaboration between the medical home and health care systems and Head Start and Early Head Start programs.

So, at this point, I would like to go ahead and introduce our first speaker. Dr. Keri Hubbard is a primary care pediatrician practicing at Children's Mercy Hospital in Kansas City, Missouri. Her areas of interest include community-based pediatrics, school-based health, education, and the impacts of poverty and chronic stress on children and families. She is the Medical Director of the Children's Mercy Clinic at Operation Breakthrough, a primary care clinic located within Missouri's largest Head Start child care center and social service facility. Working in collaboration, Children's Mercy and Operation Breakthrough partner together to provide comprehensive care for many of Kansas City's most vulnerable children. And with that, I'll turn it over to Dr. Hubbard.

Keri Hubbard: Thanks, Heather, and thanks to all of you for joining with us today as we explore ways to make connections between the world of pediatric health care and the world of early childhood

education. In some cases, the connections may have existed for years, and in other cases, they may be innovative and new, but regardless, making the connections between health care and early childhood education really just makes sense. These are connections that truly contribute to healthy and successful children, to strong families, and to strong communities.

So, the connection that I'm going to talk about today is a collaborative partnership we have here in Kansas City, Missouri, between Children's Mercy Hospital, a tertiary care pediatric medical center, and Operation Breakthrough, which, as Heather said, is Missouri's largest single-site early childhood education and social service facility. So, if we talk a minute about the players, first we have Operation Breakthrough, and back in , two sisters, Sister Berta and Sister Corita, recognized a need for quality child care for the working poor. And in response to that need, they opened a child care center, initially caring for about children ranging from infants to preschoolers. Five years later, before and after school child care was offered, and now years later, Operation Breakthrough serves more than children from low-income families each week day.

Over the course of those years, not only did the number of children and families served increase, but so too did the breadth of services offered. What started out simply as a place for children to come while mom was at work has now evolved into what is truly a multi-disciplinary center. And the services provided now by Operation Breakthrough include both Head Start and Early Head Start programming, health care including medical and dental services on site, occupational therapy, physical therapy, speech, mental and behavioral health services for both children and adults, social workers and family advocates, employment and educational support for adults, parenting support, as well as resources to help families meet basic needs such as food, clothing, transportation, and utilities. And as needs are identified, one thing really started to stand out, and that is the idea that children don't exist just in isolation but rather in the context of families and in the context of community. And it became very clear that if we want to make an impact on a child's life, it's really essential to take a two or even three-generational approach. We need to look at the relationships between the parent and the child, between the parent and other parent, between the family members. We need to acknowledge the challenges that our families face with poverty, trauma, and adverse childhood experiences. And possibly most importantly we need to look at the available resources and truly help families identify their strengths.

So, switching gears a little bit. Now we're going to look at the other player in this collaboration, and that is Children's Mercy Hospital. And like Operation Breakthrough, we also were founded by two sisters, although in this case the biological type, not the religious type. And like Operation Breakthrough, we, too, have seen tremendous growth over the years. We are the only children's tertiary care system in the region. We have 350 in-patient beds, five hospitals, five urgent care sites. We're a Level 1 trauma center, and we have over 40 different pediatric sub-specialties and employ over 6 ,500 people. Despite our size and our growth, there is still an emphasis here on high-quality primary care for the children in the Kansas City area and especially for those children and families with limited resources who may not have other places to go. And with that emphasis in place, over time the idea emerged that not only should we exist as a pediatric center welcoming the community into our ivory towers, but that maybe we can make additional impact by reaching out and leading our families where they are in their communities rather than waiting for them to come to us. And it really is in that spirit of entering into the

community that is at the heart of our evolving partnership between Head Start and the medical home. Our clinic at Operation Breakthrough is a partnership that began in 1995 with a single nurse operating a sick bay for those kids who were too sick to be in the classroom but not quite sick enough to be at home. Over time, just like OB, Operation Breakthrough has grown exponentially, and Children's Mercy has grown. Our clinic has grown as well, first adding a nurse practitioner, then in 2010 adding a medical director, and over time growing into a fully functional pediatric clinic. Our staff now includes two pediatricians, two nurse practitioners, two full-time nurses, a health facilities assistant. And with our current staffing, we are able to provide full on-site clinic coverage and full school nursing coverage from 7:30 each morning until 6:30 at night.

As we look as this partnership between Head Start and the pediatric medical home, some unique aspects become apparent. First and foremost, we're physically located in the same building, allowing us to provide one-stop shopping for our families. Additionally, we're able to meet families on their turf where they feel more comfortable, have a sense of security and control that allows us to foster trust and have open communication with our families. We've found that our families tend to trust the space and, therefore, they trust us. And as we're all aware, that healthcare is really a combination of biological, psychological, and social factors. At our site, not only are we able to see and experience the interplay of these factors each and every day, but truly we wouldn't be able to avoid them if we wanted to. So, there is definitely an advantage to this collaborative arrangement.

There are challenges, as well. Perhaps the greatest challenge that we face on a daily basis is clearly defining roles and boundaries. And while it is great and necessary the partnership can work together, at the end of the day, everybody needs to be clear on where responsibilities ultimately lie and whether it is deciding who is ultimately responsible for watching a child too sick to be in the classroom but not sick enough to require clinic visits, whether it's deciding who is responsible for ultimately enforcing Head Start and state licensing requirements, or even decisions as to who and how arrangements are made to ensure cleaning and maintenance of shared space and equipment. Along with establishing roles and defining roles, boundaries also become very important, and we also find ourselves walking a fine line between the idea of empowering families versus enabling them. And I think by nature health care providers and educators alike tend to be helpers and doers, and we want to act and we want to respond, but ultimately, part of our responsibility is also to teach our parents how to advocate for their children and prepare them for the day when they're no longer within our walls. Another challenge we face is adjusting discrepancies that sometimes exist between AAP recommendations and state regulatory requirements. Sometimes things that seem simple on the surface, such as defining a fever or defining diarrhea and when a child needs to go home, can become very complex and multi-layered issues. And finally, we face process barriers.

Along with the advantages of multiple community organizations coming together, some of the challenges we face are not only how do we integrate that care, but in this day and age of EMRs, how do we integrate documentation as well. And while some of our challenges are easier to overcome than others, ultimately we know that the benefits our families receive from our partnership far outweigh the challenges. It's really difficult to overstate the advantages of one-stop shopping. Our families face so many barriers to access, from holding jobs that don't have benefits or options to take time off to take

their children to the doctor, lack of reliable transportation, or simply not being in a place in life that allows for the ability to plan too far in the future. And when we can offer multiple services under one roof, we can start breaking down these barriers and improve access to care. Families also benefit from our ability to coordinate care and take a much more proactive approach to health care. And we see this every day. Not only can I develop a treatment plan, but I can actively link families directly to services such as physical therapy, occupational therapy, speech, behavior therapy, etcetera, that can be provided directly in the classroom. And I have the opportunity to see firsthand how treatment plans are implemented and if changes need to be made. We see our kids not only in the clinic but also in the classroom each and every day, so we know if the child is or isn't responding to treatment, and we can pick up the phone and reach out to a parent rather than waiting for a crisis to send the child and family to the ER. And in this way, we're really able to better utilize health care resources, and perhaps even more importantly, we see that our daily presence helps foster relationships and trust between clinic staff, Head Start staff, and families.

So often the question comes up, and they say, "Okay, so you work in a daycare all day. What exactly do you do?" And the answer to that really can be broken down into three main parts. First, we function as a community-based primary care clinic, and as such, we provide well child care, acute care visits, management of chronic medical conditions, vaccines, labs. Really anything that you would receive in an outside service, an outside clinic, we can do as well. We are open to the community as well as the kids at Operation Breakthrough, so you don't have to attend the Head Start program to be seen in our clinic as a primary care service. As a second role, we function as a school clinic, so we here Head Start meet their compliance standards. We physically touch base, or rounds, in all 22 classrooms each morning, and this gives us an opportunity to touch base with the teachers, to answer questions, to address concerns, and just really to see what's going on in the classroom on a day-to-day basis. And finally, we serve as a center for advocacy and education. We frequently have learners working with us in the clinic and we are constantly striving to find innovative ways to build resiliencies so our children and families can be defined by their strength and not by their hardship.

So when we look at the scope of our practice, we realize pretty quickly that the medical home and Head Start truly share many common goals, and we strive to optimize the well-being and potential of children and families. We strive to optimize readiness and ability to develop and learn. We address toxic stress. We work to ameliorate adverse childhood experiences. We work together to respond to trauma and to build resistance. Together we work towards ensuring that every child receives preventative health care, and we work towards universal immunization, and together we take innovative approaches to integrating services, breaking down silos, and providing comprehensive care, hopefully without duplication. So at the end of the day, what have we learned about collaboration as evolved? Truly we've learned that we're all in this together, that creativity is a must. In order for collaborations to work, not only do you need to be willing to think outside of the box, but sometimes we have to realize that the box may not even exist. And partnerships between health care and education between medical homes and Head Start just makes sense.

When we work together, we can break down silos, and we recognize that together we can become more than simply a sum of our individual organizations. Together we truly can build stronger families and

stronger communities. And the final lesson I think we've learned is that you don't have to wait to find the perfect model or to have all the pieces fit together perfectly to get started. Sometimes you just jump in, start small, take baby steps, and together we truly can do great things.

Heather: Thank you, Dr. Hubbard, for this great example of collaboration. As a reminder, we'll be addressing questions at the end, but you can enter them at any time throughout the presentation. So, I'd like now to introduce our second panelist, Dr. Kelly Kreisler. Dr. Kreisler is a board-certified pediatrician who has been in practice since 2002. Following graduation from pharmacy school, Dr. Kreisler attended West Virginia University School of Medicine where she completed her pediatric residency. After working for six years at a large suburban pediatric hospital and volunteering at an inner-city pediatric safety net clinic, Dr. Kreisler returned to training. She completed two years of developmental behavioral pediatric fellowship and received a Master of Public Health from Kansas University Medical Center.

After graduation, she worked as general pediatric faculty at KUMC where her clinical and research focus was medically underserved children, particularly immigrants and refugees. She is active in the Kansas chapter of the American Academy of Pediatrics where she chairs the Global and Immigrant Health Task Force. She recently completed a three-year term on the board of a pediatric safety net clinic and currently sits on the community council of Reach Out and Read Kansas City, a clinic-based early literacy program. She is the Chief Medical Officer at Health Partnership Clinic, a community health center in a suburb of Kansas City. Dr. Kreisler has four children, two dogs, and a husband with super-human patience. So Dr. Kreisler, I'll turn it over to you.

Kelly Kreisler: Thanks, Heather. It's great to be here today. I really appreciate the opportunity to talk about this topic that's near and dear to my heart. So, today I'm going to talk about some poverty statistics, suburban poverty, which I hope I'll be able to convince you that that's not an oxymoron. I'm going to talk about the AAP policy statement on community pediatrics, and hopefully I'll convince you that this is why we should be working together.

I'm going to talk about community health centers in general, health partnership clinic and Head Start, and some tips for creating partnerships. So these are statistics that always surprise me, even when I read them aloud. Sixteen million U. S. children at or below the federal poverty level; 32.4 million U. S. children live in low-income households. So a lot of kids that need us. And this is a statistic that most people find very surprising and often people don't believe it, but there are now more people living in poverty in the suburbs than in big cities or rural areas. So, that's about 16.4 million poor people in the suburbs compared to 13.4 million in big cities and 7.3 million in rural areas.

I want to share some recent headlines with you to let you know that suburban poverty is a big problem. So, you can see Kansas leads the middle class, from The American Prospect. That highlighted our clinic. Increase in suburban poor population, poverty in the suburbs is up sharply nationwide. I won't go through all of these and read them to you, but I just wanted everybody to know that not only does suburban poverty exist, but it's a really big problem in this country.

So the AAP policy statement from March , Community Pediatrics: Navigating the Intersection of Medicine, Public Health, and Social Determinants of Child Health. I think the statement could really just be a statement of why should community pediatricians be collaborating with Head Start. So it's the synthesis of clinical practice and public health principles to promote the health of all children within the context of the family, school, and community, and the commitment to collaborate with community partners to advocate for and provide quality services equitably for all children. It's a perspective that expands the pediatrician's focus from one child to the well-being of all children in the community and the recognition that family, education, social, cultural, spiritual, economic, environmental, and political forces affect the health and functioning of children.

And I have to tell you, it makes me tired just to read it. To think about doing it every day can make me just exhausted. So, one day at a time we do this and one collaboration at a time. So, our Head Start collaboration, at Health Partnership Clinic, we partner with two local Head Starts and we have -- our own staff is on the Health Advisory Committee of both Head Starts. We provide on-site EPSDT exams, so just well child checks. We do labs such as lead and hemoglobin, hearing/vision screening. We provide dental services and vaccines on site. I wanted to let everybody know a little bit about what community health centers are. So they were funded by HRSA about years ago to help bridge health care for people who couldn't afford it. So they are generally and medically underserved areas. It's very unusual to find one here in the suburbs despite our large number of people living in poverty. We all have sliding scale fees. We all have patient board members. And last -- the last statistics available from 2012, there were 21.1 million patients served by community health centers, and 93 percent of those patients were at or below 200 percent federal poverty level. So, you can see community health centers make a natural partner for Head Start.

Health Partnership Clinic was a free clinic for 20 years, and it only served residents that lived in Johnson County, Kansas, and in 2012 became a community health center. At that time, our outreach into the community expanded greatly. So, we're a much newer collaboration than the collaboration that Dr. Hubbard described. We have an integrated medical and dental electronic medical record, and we have a behavioral health consultant here in our clinic. So, we have a psychologist that's available to us during our regular primary care clinic visit to come in and talk about any family stress or mental health diagnosis, sleep problem. Really just anything that the family needs a little extra support on, she's available to come in and do that right during the well child check.

We're also a Level patient-centered medical home, and we partner with lots of organizations. "Partnership" right in our name. So, I wanted to list some organizations that we work with including Head Start. We work with the fire department. We work with our local health departments, the Boys and Girls Clubs of America, Reach Out and Read, substance abuse prevention and treatment centers. We work with our local chapter of the American Academy of Pediatrics and with Kansas University Medical Center, our state refugee health coordinator, faith based organizations, homeless shelters, and other practitioners.

And I just bring these -- list these for you to let you know that we know we can't alone take care of these children and families. We need to reach out to other partners to do their part so that we can better do

our part. I'm going to describe our collaboration with one of the Head Starts. I'm just going to call it Head Start A. I have two that I'm going to talk about. Last year we did 170 comprehensive exams prior to the start of the school year. We did that over a four-day period, and the appointments were scheduled by the health coordinator. We got all of our consents signed prior to the event. And some things that were key for us to be successful that day, those days, were that the vaccine records were made available to us prior to the event so we could prepare. Reminder calls were made by the health coordinator. We found, much like Dr. Hubbard talked about, trust is very important. The families know this person very well, and if she tells them, "You need to come at this time, this is very important," they show up.

We have almost 100 percent show rate for, for those appointments. We also have a navigator here at Health Partnership Clinic who's a bilingual person who helps with getting people signed up for Medicaid and who's just generally able to help people navigate our system, the health care system, and she is a great liaison between Head Start and Health Partnership Clinic. And I think it's very important to have someone identified who can be that liaison for you if you're going to have one of these successful collaborations. So we give a copy of the exam to the patient and to the Head Start at the end of our physicals that day, and we explain all of the follow-up recommendations. One thing that's important to me, we are a patient-centered medical home, but we're not the medical home for all of these children. And so some of them have a medical home, and because of the barriers that they face, not being able to get an appointment or transportation or the hours weren't convenient, they weren't able to get in, and so we will share information. We'll get the parent, if they want to go back for their follow-up, to their own medical home.

We will share information with their medical home to help make that as easy as possible. We also offer monthly dental services on site at Head Start, and if you've ever seen that done, it's amazing. As a pediatrician, I've been amazed to watch these dentists and dental hygienists in action. They just get in and out. They're able to do the cleanings, the exams, fillings right there on site, and because the other kids are doing it and the teachers are there and the teachers are calm trusted adults, the kids just cooperate and get their teeth cleaned, their fillings done. It's amazing to watch these three and four-year-olds get their dental care at the Head Start. This particular Head Start applied for a grant which was funded to have us provide services. They built out a clinic room for us to provide on-site clinic services for children and families at the site. So, that's been really important to us. Dr. Hubbard talked about looking at multiple generations. It's been our goal to treat all the caregivers in that child's life because healthy caregivers really make for healthier children. Some other just things that make us successful are that they provide us access to the Internet on site, so we're able to utilize our own electronic medical record and keep records for those kids that will come back to see us as their medical home.

And some children will come back to see us. Like I said, others will have a provider that they'll go back to. And we're happy to share that information with them. This Head Start applied for and got to be a Reach Out and Read site, so we're able to give books to these children at all of their well child checks. We're also, because of our collaboration, we were able to respond to a scabies outbreak very quickly in this Head Start. It had to be shut down. We were able to take care very quickly of all the children and caregivers including Head Start employees that needed it. I participate on the Head Start Advisory -- Health Advisory Council for this Head Start, as does our dental outreach director. We participate in

family nights. And I already talked about the grant for the on-site clinic. We are currently just doing one-half day per month at that clinic. So there's another Head Start that we partner with very similar in distance from our clinic in size, and we did exams at that school last year and hemoglobin and lead testing on ten more children.

We also provide monthly dental care on site. So, I wanted to end with some tips that I've learned over the years for creating partnerships, and it sounds simple, but it's really important, so you need to show up, and that doesn't mean just showing up at your clinic. That means showing up at family night for Head Start, showing up at other kinds of events, being out in the community where people can see you and know that you are really committed to caring for their well-being. You need to listen. This can be hard for physicians. Some of you may know this. We like to talk and we sometimes have a hard time listening, but I've found that if you sit back and listen to what other people have to say, you're going to learn a lot more and you're really going to develop a lot more credibility a lot faster. Humility is another really important characteristic to have when you're working with a place like Head Start that knows these children very, very well. It's important to go in and recognize the expertise of others in the community. And offer to help with the community-identified needs, so don't come in saying, "I know the answers. Let me come in and fix this for you. "

Make sure that you're listening to what the community needs. Share resources. This can be difficult. In times and places of limited funding, people kind of want to compete sometimes for resources, but we've been the most successful by sharing resources including the grant that Head Start applied for. And keep showing up. Sometimes it gets tiring, but it's important that somebody from your organization, if not you, somebody is always there for these important community events. And that's where I'm going to end my talk.

Heather: Thank you so much, Dr. Kreisler. The data you presented were really great and it's so -- it's fantastic just to hear about what your clinic is doing and how you've been able to build these great partnerships. So thank you very, very much. I'd like to move now to our final speaker, Mr. Steve Shuman.

Mr. Shuman is a Training and Technical Assistance Specialist in the Head Start National Center on Health. Mr. Shuman brings 40 years of experience in early childhood education and public health, running community and state-level programs, training educators, creating materials, developing policy, and assisting child and family-focused agencies reach levels of excellence. He is a co-author of several publications including Breastfeeding Works, How to Meet the Needs of Breast-Fed Babies and Child Care, Growing Up Healthy, and Relationships, Resiliency, and Readiness: Building a System of Early Care and Education Mental Health Services, as well as a number of journal articles on health education, skin cancer prevention, and nutrition. He has contributed to the development and implementation of numerous training and technical assistance efforts for providers and practitioners within the Head Start child care and public health communities. And with that, we'll turn it to Mr. Shuman. Thank you so much.

Steven Shuman: Thanks, Heather. We've heard two incredibly terrific examples from Dr. Kreisler and Dr. Hubbard of partnering with the medical community and Head Start programs. I'm going to talk about partnering from a different angle and how the Office of Head Start has seen fit to develop these partnerships for stronger families and stronger communities. The focus of Head Start health services is to prevent health problems whenever possible by carefully addressing the needs of enrolled children. Effective partnerships are the key to the success of this approach. When Head Start first began almost years ago, voluntary community health providers offered many health services on site such as immunizations and medical and dental treatment.

However, today Head Start programs place a greater emphasis on partnerships with local providers to connect families to their medical and dental homes right in their communities. These partnerships enable Head Start to respond to changes in the health care delivery system and the unique needs of individual communities. Did you know that serving on a local Head Start Health Services Committee, or an HSAC, can impact the health of hundreds of children in your community? That sharing your expertise as a pediatrician by serving on an ASAC can help improve the health of children from birth through age five, and that Head Start and Early Head Start programs operate under regulations that can reinforce anticipatory guidance and other messages?

So, what is this thing called a Health Services Advisory Committee? The Health Services Advisory Committee brings together staff, parents, and community members to address emerging health issues, establish and review health plans, and mobilize community resources to assist programs in developing, implementing, and evaluating program and school readiness goals. The Improving Head Start -- excuse me, the Improving Head Start for School Readiness Act of 2007 requires programs to promote better linkages between Head Start agencies and other child and family agencies including agencies that provide health, mental health, family services, other child and family support services such as services for children with disabilities, the local school system for early intervention programs.

What do Head Start and Early Head Start -- why do they have an HSAC? Well, the HSAC has broad advisory functions as determined by the local program. The Head Start Program Performance Standards, the requirements that Head Start programs work under, require that every Head Start program form and maintain a Health Services Advisory Committee to advise the planning, operation, and evaluation of health services in Head Start and Early Head Start programs. Each program's HSAC may offer guidance and support to build and maintain high-quality health services and health-related policies that promote school readiness. The HSAC support improved outcomes by building relationships among the threads of the community. It helps to weave a close-knit group of parents, Head Start staff, and health providers working together to improve health services to low-income children and their family.

Families play an essential role in the HSAC as they bring their perspective about the availability and quality of local services as well as the gaps and barriers to care for low-income families. The perspective creates -- excuse me, this perspective creates the context for a family-centered focus for conversation with other HSAC members. Local health providers are among the possible community partners including pediatricians, nurses, nurse practitioners, dentists, nutritionists, mental health providers, special

education and other related service providers, staff from the WIC program, other local social service agencies and emergency responders.

As you heard from Dr. Hubbard and Dr. Kreisler, the list could go on and on. There really is no limit. Head Start managers and staff work into the HSAC their in-depth knowledge of program practices as well as the day-to-day needs of children and families and the challenges they face. We're going to see a clip of one Health Services Advisory Committee in action. Can you bring up the first video, please?

[Video Begins]

[Music begins]

Narrator: This Health Services Advisory Committee empowers parents by teaching them about the health care system and how to make it work for their children.

Marty Varela: The Health Service Advisory Committee is doing something that's really unique and that's that they're taking a problem that seems like it belongs to a certain group and they're exposing it, you know, they're shining light on it.

Tracey Lee: Our Health Advisory Committee helped us write a grant, and a few of those members sort of became a peer help committee, and we wrote a grant all around helping parents teaching other parents how to navigate the health care system.

Shannon Blas: We train Head Start parents. They learn to navigate through the managed care system and how to partner with their doctor. Then they go back to their site and they do what's called a teach-back.

Tracey: When we tell them they're going to get up in front of a group of other parents, a lot of them say, "I can't see myself doing that." But then, you know, weeks later they are doing it, and the response they get from their parents that they're teaching I think is so wonderful, that they really do become energized.

Marty: In the description, it says, "How big is the gash?"

Narrator: Parents like Marty actively participate on the committee and help teach other Head Start families to understand the health care system. With three small children of her own, Marty knows how difficult it can be to manage the health care of children.

Marty: This program has given me some information, and it's just like, you know, you've got a secret and you want to tell as many people as possible. They're much more willing to listen to you because they perceive that you're one of them, and I am. I'm, you know, first and foremost, a Head Start parent.

Tracey: To hear parents say that they're advocating for themselves in their doctor's offices and that they carry history of their child, you know, with them from provider to provider or when they move, for us to hear that I think is the biggest success.

Stuart Short: There's a lot of personal satisfaction. I find that I'm able to use my pediatric expertise to help make certain policies and give certain guidelines which are beneficial to preschoolers.

Woman: I think the most important component of Head Start is that they're not trying to do it all by themselves. They're collaborating with community members.

[Video ends]

Steven: Thanks. So you saw one HSAC in action with the parents and community providers working together for everyone's benefit. Dr. Kreisler, I understand you've been on a Health Services Advisory Committee. You want to tell us a little bit about your experiences?

Kelly: Sure, I'd be happy to do that. I find, again, like I said earlier, the most important thing for me has been to listen, so I've been able to offer some guidance, I think, when it comes to doing things like revealing policies and procedures for the organization, but one thing that helps me the most about being on the committee far more, I think, than it helps the Head Start is to learn what other people's perspectives are and what the needs of these families are in the community.

Steven: Thank you. So, in the big picture, how does that HSAC function? Well, the HSAC plays this important role in weaving community actions as we've seen and heard, and ensuring that Head Start programs provide comprehensive, integrated, and effective health services to children and their families. HSACs can assist local programs in a variety of activities including developing and reviewing health-related plans, policies, and procedures, training staff and parents on health topics, accessing community health services, and committee members can offer their services on a volunteer basis and are not compensated for their participation. Meeting schedules are best determined by the activities and members of the HSAC. The standard, the requirement doesn't spell out how many times an HSAC should meet. That should be something that's driven by both the membership and the HSAC's goals and objectives.

Working professionals of any kind have always faced many challenges to working together: funds, distance, time management. But today's technology offers a wide variety of virtual meeting tools to not only help meet these challenges but also to keep connected between meetings. Virtual meetings allow a Health Services Advisory Committee to draw upon a wider group of members including working parents and non-local professionals with relevant knowledge and skills. Attendees can take an hour or so to attend the meeting from the convenience of their home or office instead of the several hours that might be needed to travel. Those unable to attend the meeting can have the benefit of reviewing an archived recording of the meeting. Attendees can network, connect, and discuss issues and trends before and after the live meeting.

These tools support together -- excuse me, these tools support working together between meetings by communicating online, sharing data, or collaborating on projects. Virtual meeting tools can be tailored to meet the needs of the HSAC members. A meeting can be attended by additional members using

something as simple as a telephone or the HSAC can create an online community to share documents and post information. Members can build productive working relationships by connecting with each other in between regular meetings. So, we're going to look at another example of our Health Services Advisory Committee. Can we bring up clip number two?

[Video begins]

[Music begins]

Woman: Because Head Start has such a strong emphasis on prevention, that the Health Services Advisory Committee's mission is not just to address problems and realize, but to be really proactive and to think of prevention and early intervention and how wonderful things can be made to happen in the community.

Bontivia: I have three kids. I have -- one is one years old, three, and seven.

Narrator: Bontivia's children were suffering from a health problem that had broader implications for the entire community.

Bontivia: They were tested at the regular health assessment, and I was called a couple of days later and they told me that they're lead level was high, and that they needed to be retested and my house needed to be checked.

Narrator: Bontivia, a member of the Health Services Advisory Committee informed the committee about this community problem.

Bontivia: I had a problem with them coming out. I called, I talked to the Director of Med, and he informed me that they had a backlog, but far as being a parent and other parents, there should have been some kind of communication of telling that you know that there's a backlog or what's going on. Nobody told me anything.

Habib Sharat: So we have like about , members coming from different areas of the community bringing their expertise, listening to the needs of the community members.

Woman: As advocates in this community, that that's totally unacceptable, right, that we will not accept that they have a backlog.

Woman: Most of the homes are over and years old. So the chances are that any place you live there is lead-based paint.

Woman: Lead is a priority.

Bontivia: They're just boosting me to call because I wouldn't have called on my own, so -- or I probably just waited till somebody might have called me back.

Theresa Shivers: The parent becomes her own advocate. I don't have to be there to hold her hand, but I do have to be there to be a role model, to give her an example to go by.

Bontivia: The people encouraged me to keep calling, so I did, and I got a great response back. Right now I'm happy to say that everything is in process. Last week someone from the lead department came and did an evaluation of the whole house to do the estimate so everything could be fixed that needs to be fixed. And I'm happy to say, too, that the lead level has gone down tremendously.

Woman: Great.

Narrator: By bringing the resources of the committee to focus on the issue, the whole community will now benefit from Bontivia's actions.

Woman: What about all of those other parents out here who don't have anyone else to march down or walk with them down this road?

Man: I would like to see this group maybe put that on the burner as an issue to be addressed.

Bontivia: Participating in more meetings, it gave me the strength and the courage to speak up.

Janet Unonu: Bon, she goes to meetings now and speak to other parents. And that's what we really want to see, because she is the one that is going to make that change in her community.

Bontivia: It turns out that they really are happy that I am there and that they can find out more things that goes on in parents' lives and their kids' lives so they can find a better way of helping people.

Woman: The more you can engage people in the community and one group brings another in, and before you know it, you know, you have a whole tapestry of people involved. This is something that's bigger than any one of us, and that really has such an impact for the future.

Narrator: The Health Services Advisory Committee, helping children, building relationships, advocating for change, empowering parents, and strengthening communities. Weaving connections that create a healthy future for children and families.

[Video ends]

Steven: So as you've seen in these two video clips, which are part of the Weaving Connections collection that you can find at the Early Childhood Learning and Knowledge Center, or ECLKC, an HSAC can be a powerful vehicle to improve the health of children in your community. An HSAC can empower parents to become their own health advocates or help them design and analyze the community health needs assessment and then take action. Other HSACs have worked to streamline program protocols or something as important as individual education plans, IEPs, for children with special healthcare needs so that all children served by the program have their individual health and learning needs met. There really is no limit to what an HSAC might choose to focus upon. It is an opportunity to think outside the box in order to better service children. An HSAC could address determining if services should be provided on site or close-by, deciding if transportation services should be obtained or routes strategically adapted to the needs of families so they can reach their medical homes, identifying and applying for external funding sources, such as federal agencies -- such as FERSA and CDC or locally as community health

foundations. They could focus on mitigating environmental hazards such as toxic contaminants, poor air quality, dangerous intersections, and areas prone to fire. By listening to families and analyzing data, an HSAC can identify much needed community resources such as having a nearby grocery store with affordable fresh produce, establishing safe walkways and bike ways to get to the Head Start program or schools, and improving opportunities for outdoor play. What can you do to be more involved in Head Start if you're not already? We have looked at how you might participate on the Health Services Advisory Committee to provide guidance in the programs health services, but there are many other opportunities for non-Head Start staff to partner with Head Start and Early Head Start. You may want to meet with Head Start staff and leave business cards with families in need of a medical home. At the same time, you may want to pick up enrollment materials that provide Head Start and Early Head Start information and have it available for families in your care.

There is always a need for more information. You could choose to write an article on health for the Head Start program's newsletter or provide health education materials Immunization, infectious disease, toxic stress are just some examples. or sessions for program staff or families. You can even have Head Start and Early Head Start staff present on their programs to your medical home staff. If you acknowledge the importance of high-quality early childhood education, you might to link your advocacy to work with Head Start collaboration offices in each state. Contact local media to promote quality early education and child care or ask as a legislative advocate. You can also bring the health community to the Head Start program by teaching pediatric residents about Head Start and consider rotation there. That goes true for nurses and for dental hygienists and dentists, the entire medical community.

You can participate in continuing medical education on Head Start and establish a more formal partnership between the Head Start and Early Head Start program and the medical practice or the institution with which you are affiliated to provide on-site clinical care. If you're looking from the Head Start program out, reach out to folks and suggest these examples of becoming more involved. If you're interested in other suggestions or working it through with the Office of Head Start National Center on Health, please write to us at nchinfo@aap.org. That's what I have to share, Heather.

Heather: Mr. Shuman, thank you very, very much. HSAC is such a great way to start collaboration or enhance what's already maybe happening between Head Start and the medical home. So, thank you so much to actually all of our speakers today for sharing your experiences and your expertise. It looks like we do have just a few minutes for some questions, and we have had some excellent questions coming in. Thank you so much for sending those in. I'm not going to go in order, and I think we definitely will not get to all of the questions during our time today, but as we said earlier on in the presentation, our speakers have graciously agreed to respond to any questions that we don't get to during this section after the call, and they'll respond to you directly and will hopefully also summarize those to be posted along with the other webinar materials. So, let's just get started then. This first question could be directed, I think, to either Dr. Kreisler or Dr. Hubbard. How can Head Start and Early Head Start programs being a partnership with a local medical center? So, I'm assuming that the program would initiate that dialog. How do you know what clinic would be the best fit for that Head Start program? If either one of you would like to reply.

Keri: Sure. This is Keri Hubbard. I can take a stab at that. And I think one place to start is when kids enroll in a Head Start program, upon that enrollment, they're asked to identify who their medical provider is. And one thing that Head Starts can do is to start looking for trends there, and if you start noticing that there are one or two offices that your students tend to seek care from, call them up and just ask. Most medical providers would love that conversation to take place and are looking for ways to help, but it may be a way of identifying what providers your kids see, and call them up and ask if you can set up a meeting to discuss the services you provide and what types of collaboration might be available.

Heather: That's great. Dr. Kreisler, anything to add to that?

Kelly: I don't, actually. I think that's really an excellent point. It's really for me just getting out there in the community, so for the Head Start to know who the kids are seeing is a great way. Maybe even showing up at the pediatrician's offices with some materials might be another way to get to know -- who lets you in the door might tell you who's going to be interested.

Heather: Great, thank you. And kind of a related question to this. Is there an advantage to working with -- or disadvantage, I guess, as far as that goes, to working with multiple medical centers, multiple medical homes? Would you stick with just one, or would you potentially recommend programs could partner with multiple sites?

Keri: I absolutely think that programs can partner with multiple sites. The fact of the matter is, the kids see multiple providers and they identify different medical homes. So, in part, I think it depends on what your collaboration looks like. In our case, where we are a clinic that's physically located on site, I don't think that model works for many different clinics to be physically located on site, but there are many, many different ways to partnership, and I think the more relationships you can have with the community, ultimately the better care that you're going to provide for the kids and families.

Heather: Great, thank you. And also, moving to the next question, then, and I'm going to -- there were a couple of questions around this, so I'm kind of grouping them together, but there were questions around how is this funded? Are you billing perhaps Medicaid or the child's -- if there is a private insurance provider, both for the medical and the dental services, some questions about funding and support for that.

Kelly: This is Kelly Kreisler. I can address that. We, as a community health center, we are charged with and receive some funding to help take care of the uninsured, so if kids are uninsured, we don't charge anything including we don't charge our sliding scale fee when we're doing services on site at places like Head Start or we work at a homeless shelter as well. So, we do bill insurance, so if a child has insurance, we will, we will bill their insurance for the services that we provide for both medical and dental insurance, and those do get paid.

Heather: Great. Dr. Hubbard, did you have anything that you'd want to add from the Operation Breakthrough side?

Keri: That's been our experience, as well. We see a predominantly Medicaid population, and we do bill Medicaid. If we have families that aren't insured, we are also set up as a non-profit institution that gets covered as community benefit, so those families don't receive a bill. But if they do have insurance for Medicaid, we bill them directly and do get reimbursed.

Heather: Great, thank you. Okay, moving on to information sharing. One of the questions is around, and I'm kind of paraphrasing a little bit, shared documentation. So how can the medical home or the health care center work together with the Head Start program to collect the information that's needed, the health-related information that Head Start requires from programs? Can either one of you talk about your experiences with that?

Kelly: This is Kelly Kreisler. I can talk about that. So, it's been very helpful for us to have the liaison from our clinic and a specific identified person at the Head Starts who work together to make sure that that information gets exchanged. We begin our process by having families sign a consent so that we're both free to share information back and forth, and then that liaison helps ensure that we get what we need and share what we need, what the Head Start needs with them.

Keri: We also do something similar. All kids, upon enrollment, we sign two consent forms. Actually one is consent that as a clinic that we can treat their children, and the other is consent that we can exchange information between Children's Mercy and Operation Breakthrough. So that exchange of information is facilitated. One of the other questions that comes up, though, is how much information is really needed and does our documentation meet the requirements of Head Start when it comes time to entering data into their database. And that was one thing that really first came to our attention not at our clinic at Operation Breakthrough but at our main primary care clinic at Children's Mercy is we kept getting repeated requests from Head Starts and other daycare centers for information that was missing from physicals or EPSDTs that we were sending over. And that really came down to a conversation that we had with the leaders of Head Start, with our medical staff, and with our IT providers as to -- so we could all get on the same page of what information was necessary, and we created a specific daycare form we can have a little bit more consistency in what information is transferred from one institution to the other.

Heather: That's great. And it kind of segues into what we'll be our last question for the presentation, I'm sorry to say. But a few different questions, and again, kind of putting them all together around some Head Start programs are performing some screenings on site there and they're having struggles with the pediatrician or the medical home, I guess in general, whatever the nature of the provider might be, recognizing those screenings as being valid and some questions around what types of screenings are appropriate to happen at the Head Start program versus, you know, that need to happen within a healthcare clinic setting. So, I'm guessing you maybe come across similar struggles, and maybe if you want to just share briefly about your own experiences, and we can certainly pursue this more after the call as well.

Keri: This is Keri Hubbard. We definitely struggle with this even when we are on site and the screenings are being performed on site, and one of the challenges we face is how to document screenings that

aren't done within our institution. I think when it comes to things like lead levels, hemoglobin, hearing screens, vision screens, height/weight, blood pressure, vital signs, those are all things that can be obtained in a Head Start environment. I think one of the most helpful ways is to provide the families with the documentation that says what screening was done and what the results were and to be as specific as possible. So, for example, as a medical provider, it's far more helpful to know that what type of vision screening or hearing screening was performed on the child and what the results were rather than just a slip of paper given to the parent saying this child failed their vision screen. So, I would say that more specific information that you can provide, the more that that's going to be accepted and acted upon.

Heather: Great. Thank you very much. Okay, thank you again to all of our speakers who just did a fabulous job of talking about many ways that collaboration can occur between Head Start programs and the medical home and health care community. If you have further questions about this topic, please don't hesitate to contact us here at the Head Start National Center on Health. Our phone number is listed there on the screen, --, and our email is there as well, nchinfo@aap.org. And as Steve mentioned, the Early Childhood Learning and Knowledge Center has our website link there, and we will send that out again after the presentation. When the webinar ends, there will be a survey poll that can be taken immediately and there'll be a follow-up email sent to every one who watched live with instructions to share the Survey Monkey link to everyone in your group who watched today's webinar. Those who take the survey immediately after the webinar will get their certificate immediately, where those who use the Survey Monkey link can expect their certificate in two to four weeks. Remember that each person who would like to receive a certificate of participation for today's webinar should complete their own individual evaluation. If you're watching the webinar as a group, again, each person in the group must complete that evaluation to get the certificate. So, thank you again so much for joining us for today's webinar. Based on the feedback to the question box, it sounds like it was an informative time, and I definitely appreciate all the information the speakers shared with us, and we look forward to your participation in future events. Thank you so much and have a great day.

[End video]